WORKER'S COMP CARRIER: JT2 INTEGRATED RESOURCES
231 MARKET PLACE, STE 381
SAN RAMON, CA 94583

CITY OF HOLLISTER
SUPERVISOR'S ACCIDENT REPORT FOR WORKER'S COMPENSATION CLAIMS

Employee Name_____ Job Title _____

Dept. _____ Supervisor_____

Date of Injury _____ Time of Injury _____

Time shift started _____am _____ pm

Address of Injury _____

What was employee doing at time of injury _____

Did Employee lose at least one full day of work? _____

Date Last Worked _____ Date Returned _____

Check Box if Still Off Work ☐ Was Employee paid a full days wages on injury date? _____

Name & Address of Physician if Employee was treated _____

_____

Accident Causes Unsafe Condition ☐ Unsafe Act ☐ Please explain

_____

_____

Corrective Action taken _____

_____

List equipment, materials or chemicals employee was using when injury occurred _____

_____

Witnesses _____

Describe Accident, (How did accident/illness occur) _____

_____

Signature of Supervisor _____

Note to Supervisor: Please fill out this form completely and forward it to the Finance Dept. along with a DWC-1 form, which is the Employee's claim for Workers' Compensation benefits. The DWC-1 form MUST be completed by BOTH employee and supervisor.